

CHAPTER 513B

SMALL GROUP HEALTH COVERAGE

Referred to in §87.4, 296.7, 331.301, 364.4, 505.8, 505.28, 505.29, 507A.4, 509.19, 513C.11, 514L.3, 514K.2, 669.14, 670.7

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SUBCHAPTER I

RATING PRACTICES — AVAILABILITY

513B.1 Title — purpose.

1. [This subchapter](#) shall be known and may be cited as the “*Model Small Group Rating Law*”.

2. The intent of [this subchapter](#) is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

[91 Acts, ch 244, §1; 93 Acts, ch 80, §1](#)

513B.2 Definitions.

As used in [this subchapter](#), unless the context otherwise requires:

1. “*Actuarial certification*” means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of [section 513B.4](#), based upon the person’s examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the small employer carrier in establishing premium rates for applicable health insurance coverages.

2. “*Base premium rate*” means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers for health insurance plans with the same or similar coverage.

3. “*Basic health benefit plan*” means a plan established by the board of the small employer health reinsurance program pursuant to [section 513B.13, subsection 8](#), paragraph “a”.

4. “*Carrier*” means an entity subject to the insurance laws and regulations of this state,

or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

5. “*Case characteristics*” means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the insurer in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of [this subchapter](#).

6. “*Class of business*” means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

a. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health insurance coverages meet one or more of the following requirements:

(1) The coverages are marketed and sold through individuals and organizations which are not participating in the marketing or sales of other distinct groupings of small employers for the small employer carrier.

(2) The coverages have been acquired from another small employer carrier as a distinct grouping of plans.

(3) The coverages are provided by a policy of group health insurance coverage through a bona fide association as provided in [section 509.1, subsection 8](#), which meets the requirements for a class of business under [section 513B.4](#). A small employer carrier may condition coverages under such a policy of group health insurance coverage on any of the following requirements:

(a) Minimum levels of participation by employees of each member of a bona fide association that offers the coverage to its employees.

(b) Minimum levels of contribution by each member of a bona fide association that offers the coverage to its employees.

(c) A specified policy term, subject to annual premium rate adjustments as permitted by [section 513B.4](#).

(4) The coverages are provided by a policy of group health insurance coverage through two or more bona fide associations as provided in [section 509.1, subsection 8](#), which a small employer carrier has aggregated as a distinct grouping that meets the requirements for a class of business under [section 513B.4](#). After a distinct grouping of bona fide associations is established as a class of business, the small employer carrier shall not remove a bona fide association from the class based on the claims experience of that association. A small employer carrier may condition coverages under such a policy of group health insurance coverage on any of the following requirements:

(a) Minimum levels of participation by employees of each member of a bona fide association in the class that offers the coverage to its employees.

(b) Minimum levels of contribution by each member of a bona fide association in the class that offers the coverage to its employees.

(c) A specified policy term, subject to annual premium rate adjustments as permitted by [section 513B.4](#).

b. A small employer carrier may establish additional groupings under each of the subparagraphs in paragraph “a” on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

c. The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

7. “*Commissioner*” means the commissioner of insurance.

8. “*Creditable coverage*” means health benefits or coverage provided to an individual under any of the following:

a. A group health plan.

b. Health insurance coverage.

- c. Part A or Part B Medicare pursuant to Tit. XVIII of the federal Social Security Act.
 - d. Medicaid pursuant to Tit. XIX of the federal Social Security Act, other than coverage consisting solely of benefits under section 1928 of that Act.
 - e. 10 U.S.C. ch. 55.
 - f. A health or medical care program provided through the Indian health service or a tribal organization.
 - g. A state health benefits risk pool.
 - h. A health plan offered under 5 U.S.C. ch. 89.
 - i. A public health plan as defined under federal regulations.
 - j. A health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. §2504(e).
 - k. A short-term limited duration policy.
 - l. The hawk-i program authorized by [chapter 514I](#).
9. “*Division*” means the division of insurance.
10. “*Eligible employee*” means an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under health insurance coverage of a small employer, but does not include an employee who works on a part-time, temporary, or substitute basis.
11. a. “*Group health plan*” means an employee welfare benefit plan as defined in section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
- b. For purposes of [this subsection](#), “*medical care*” means amounts paid for any of the following:
- (1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.
 - (2) Transportation primarily for and essential to medical care referred to in subparagraph (1).
 - (3) Insurance covering medical care referred to in subparagraph (1) or (2).
- c. For purposes of [this subsection](#), a partnership which establishes and maintains a plan, fund, or program to provide medical care to present or former partners in the partnership or to their dependents directly or through insurance, reimbursement, or other method, which would not be an employee benefit welfare plan but for this paragraph, shall be treated as an employee benefit welfare plan which is a group health plan.
- (1) For purposes of a group health plan, an employer includes the partnership in relation to any partner.
- (2) For purposes of a group health plan, the term “*participant*” also includes both of the following:
- (a) An individual who is a partner in relation to a partnership which maintains a group health plan.
 - (b) An individual who is a self-employed individual in connection with a group health plan maintained by the self-employed individual where one or more employees are participants, if the individual is or may become eligible to receive a benefit under the plan or the individual’s beneficiaries may be eligible to receive a benefit.
12. a. “*Health insurance coverage*” means benefits consisting of health care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.
- b. “*Health insurance coverage*” does not include any of the following:
- (1) Coverage for accident-only, or disability income insurance.
 - (2) Coverage issued as a supplement to liability insurance.
 - (3) Liability insurance, including general liability insurance and automobile liability insurance.
 - (4) Workers’ compensation or similar insurance.

- (5) Automobile medical-payment insurance.
- (6) Credit-only insurance.
- (7) Coverage for on-site medical clinic care.
- (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. “Health insurance coverage” does not include benefits provided under a separate policy as follows:

- (1) Limited scope dental or vision benefits.
- (2) Benefits for long-term care, nursing home care, home health care, or community-based care.
- (3) Any other similar limited benefits as provided by rule of the commissioner.

d. “Health insurance coverage” does not include benefits offered as independent noncoordinated benefits as follows:

- (1) Coverage only for a specified disease or illness.
- (2) A hospital indemnity or other fixed indemnity insurance.

e. “Health insurance coverage” does not include Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided to coverage under group health insurance coverage.

f. “Group health insurance coverage” means health insurance coverage offered in connection with a group health plan.

13. “Index rate” means, for each class of business for small employers, the average of the applicable base premium rate and the corresponding highest premium rate.

14. “Late enrollee” means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, provided the initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if any of the following apply:

- a. The individual meets all of the following:
 - (1) The individual was covered under creditable coverage at the time of the initial enrollment.
 - (2) The individual lost creditable coverage as a result of termination of the individual’s employment or eligibility, the involuntary termination of the creditable coverage, death of the individual’s spouse, or the individual’s divorce.
 - (3) The individual requests enrollment within thirty days after termination of the creditable coverage.

- b. The individual is employed by an employer that offers multiple health insurance coverages and the individual elects a different coverage during an open enrollment period.

- c. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee’s health insurance coverage and the request for enrollment is made within thirty days after issuance of the court order.

- d. The individual changes status and becomes an eligible employee and requests enrollment within sixty-three days after the date of the change in status.

- e. The individual was covered under a mandated continuation of group health plan or group health insurance coverage plan until the coverage under that plan was exhausted.

15. “New business premium rate” means, for each class of business as to a rating period, the lowest premium rate charged or offered by the small employer carrier to small employers for newly issued health insurance coverages with the same or similar coverage.

16. “Preexisting conditions exclusion” means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

17. “Rating period” means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

18. “Small employer” means a person actively engaged in business who, on at least fifty

percent of the employer's working days during the preceding year, employed at least one and not more than fifty full-time equivalent eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation are considered one employer.

19. “*Small employer carrier*” means any carrier which offers health benefit plans covering the employees of a small employer.

20. “*Standard health benefit plan*” means a plan established by the board of the small employer health reinsurance program pursuant to [section 513B.13, subsection 8](#), paragraph “a”.

[91 Acts, ch 244, §2; 92 Acts, ch 1167, §1; 93 Acts, ch 80, §2, 3; 94 Acts, ch 1176, §9; 95 Acts, ch 185, §9; 97 Acts, ch 103, §2 – 11; 98 Acts, ch 1057, §8; 2000 Acts, ch 1023, §20; 2001 Acts, ch 69, §13, 39; 2007 Acts, ch 57, §3 – 5, 8; 2007 Acts, ch 215, §255; 2009 Acts, ch 118, §20; 2011 Acts, ch 70, §26, 49; 2017 Acts, ch 148, §37](#)

Referred to in [§135H.3, 509.1, 509.3, 509A.13B, 514A.3B, 514B.9A, 514C.14, 514C.15, 514C.16, 514C.17, 514C.22, 514C.27, 514C.31, 514F5, 729.6](#)

513B.3 Applicability and scope.

[This subchapter](#) applies to a health benefit plan providing coverage to the employees of a small employer in this state if any of the following apply:

1. Any portion of the premium or benefits is paid by or on behalf of the small employer.
2. An eligible employee or dependent is reimbursed in any manner by or on behalf of the small employer for any portion of the premium or benefits.

3. The health insurance coverage is treated by the employer or any of the eligible employees or dependents as part of a coverage or program for the purposes of [section 106, 125, or 162](#) of the Internal Revenue Code as defined in [section 422.3](#).

4. *a.* Except as provided in paragraph “b”, for purposes of [this subchapter](#), carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by [this subchapter](#) shall apply as if all health insurance coverages delivered or issued for delivery to small employers in this state by such carriers were issued by one carrier.

b. An affiliated carrier which is a health maintenance organization possessing a certificate of authority issued pursuant to [chapter 514B](#) shall be considered to be a separate carrier for the purposes of [this subchapter](#).

c. Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health insurance coverages delivered or issued for delivery to small employers in this state if the arrangements would result in less than fifty percent of the insurance obligation or risk for such health insurance coverages being retained by the ceding carrier.

[91 Acts, ch 244, §3; 92 Acts, ch 1167, §2; 97 Acts, ch 103, §12, 13](#)

513B.4 Restrictions relating to the premium rates.

1. Premium rates for health benefit plans subject to [this subchapter](#) are subject to the following requirements:

a. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent.

b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent of the index rate.

c. The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for

the most similar health insurance coverage into which the small employer carrier is actively enrolling new insureds who are small employers.

(2) An adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

d. Any adjustment in rates for claims experience, health status, and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

2. a. [This section](#) does not affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

b. Case characteristics other than age, geographic area, family composition, and group size shall not be used by a small employer carrier without the prior approval of the commissioner.

c. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to coverage design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. A small employer carrier shall treat all health insurance coverages issued or renewed in the same calendar month as having the same rating period.

3. For purposes of [this section](#), a health insurance coverage that contains a restricted network provision shall not be considered similar coverage to a health insurance coverage that does not contain such a provision, if the restriction of benefits to network providers results in substantial differences in claims costs.

4. A small employer shall not be involuntarily transferred by a small employer carrier into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

5. Notwithstanding [subsection 1](#), the commissioner, with the concurrence of the board of the Iowa small employer health reinsurance program established in [section 513B.13](#), may by order reduce or eliminate the allowed rating bands provided under [subsection 1](#), paragraphs "a", "b", and "c", or otherwise limit or eliminate the use of experience rating.

6. Notwithstanding [subsection 4](#), a small employer carrier may offer to transfer a small employer into a different class of business with a lower index rate based upon claims experience, implementation of managed care or wellness programs, or health status improvement of the small employer since issue.

91 Acts, ch 244, §4; 92 Acts, ch 1167, §3 – 7; 93 Acts, ch 80, §4; 94 Acts, ch 1176, §10 – 12; 97 Acts, ch 103, §14 – 17; 2001 Acts, ch 69, §14, 15, 39; 2002 Acts, ch 1111, §13; 2007 Acts, ch 57, §6, 8; 2012 Acts, ch 1023, §157

Referred to in §513B.2, 513B.4A, 513B.13, 513B.17

513B.4A Exemption from premium rate restrictions.

A Taft-Hartley trust or a carrier with the written authorization of such a trust may make a written request to the commissioner for an exemption from the application of any provisions of [section 513B.4](#) with respect to health insurance coverage provided to such a trust. The commissioner may grant an exemption if the commissioner finds that application of [section 513B.4](#) with respect to the trust would have a substantial adverse effect on the participants and beneficiaries of such trust, and would require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

An exemption granted under [this section](#) shall not apply to an individual if the individual participates in a trust as an associate member of an employee organization.

[93 Acts, ch 80, §5; 97 Acts, ch 103, §18](#)

513B.4B Small employer incentives — suspension or modification of premium rate restrictions.

1. In order to encourage voluntary participation in wellness or disease management programs, a small employer carrier may offer premium credits or discounts to a small employer for the benefit of eligible employees of that small employer who participate in such a program. An employee shall not be penalized in any way for not participating in such a program.

2. The commissioner shall adopt, by rule or order, provisions allowing suspension or modification of premium rate restrictions to enable a small employer carrier to provide premium credits or discounts to a small employer based on measurable reductions in costs of that small employer, including but not limited to tobacco use cessation, participation in established wellness or disease management programs, and economies of acquisition or administration.

[2007 Acts, ch 57, §7, 8](#)

513B.5 Provisions on renewability of coverage.

1. Health insurance coverage subject to [this chapter](#) is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except for one or more of the following reasons:

a. The health insurance coverage sponsor fails to pay, or to make timely payment of, premiums or contributions pursuant to the terms of the health insurance coverage.

b. The health insurance coverage sponsor performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the carrier's minimum participation requirements.

d. Noncompliance with the carrier's employer contribution requirements.

e. A decision by the carrier to discontinue offering a particular type of health insurance coverage in the state's small employer market. Health insurance coverage may be discontinued by the carrier in that market only if the carrier does all of the following:

(1) Provides advance notice of its decision to discontinue such plan to the commissioner. Notice to the commissioner, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected small employers, participants, and beneficiaries.

(2) Provides notice of its decision not to renew such plan to all affected small employers, participants, and beneficiaries no less than ninety days prior to the nonrenewal of the plan.

(3) Offers to each plan sponsor of the discontinued coverage, the option to purchase any other coverage currently offered by the carrier to other employers in this state.

(4) Acts uniformly, in opting to discontinue the coverage and in offering the option under subparagraph (3), without regard to the claims experience of the sponsors under the discontinued coverage or to a health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

f. A decision by the carrier to discontinue offering and to cease to renew all of its health insurance coverage delivered or issued for delivery to small employers in this state. A carrier making such decision shall do all of the following:

(1) Provide advance notice of its decision to discontinue such coverage to the commissioner. Notice to the commissioner, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected small employers, participants, and beneficiaries.

(2) Provide notice of its decision not to renew such coverage to all affected small employers, participants, and beneficiaries no less than one hundred eighty days prior to the nonrenewal of the coverage.

(3) Discontinue all health insurance coverage issued or delivered for issuance to small employers in this state and cease renewal of such coverage.

g. The membership of an employer in an association, which is the basis for the coverage which is provided through such association, ceases, but only if the termination of coverage under this paragraph occurs uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner finds that the continuation of the coverage is not in the best interests of the policyholders or certificate holders, or would impair the carrier's ability to meet its contractual obligations.

i. At the time of coverage renewal, a carrier may modify the health insurance coverage for a product offered under group health insurance coverage in the small group market, for coverage that is available in such market other than only through one or more bona fide associations, if such modification is consistent with the laws of this state, and is effective on a uniform basis among group health insurance coverage with that product.

2. A carrier that elects not to renew health insurance coverage under [subsection 1](#), paragraph "f", shall not write any new business in the small employer market in this state for a period of five years after the date of notice to the commissioner.

3. [This section](#), with respect to a carrier doing business in one established geographic service area of the state, applies only to such carrier's operations in that service area.

[91 Acts, ch 244, §5; 92 Acts, ch 1167, §8, 9; 93 Acts, ch 80, §6; 97 Acts, ch 103, §19; 2017 Acts, ch 148, §38](#)

Referred to in [§513B.10](#)

513B.6 Disclosure of rating practices and renewability provisions.

A small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of all of the following:

1. The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer.

2. The provisions concerning the small employer carrier's right to change premium rates and factors, including case characteristics, which affect changes in premium rates.

3. The provisions relating to any preexisting condition provision.

4. The provisions relating to renewability of coverage.

[91 Acts, ch 244, §6; 92 Acts, ch 1167, §10; 97 Acts, ch 103, §20, 21; 2017 Acts, ch 148, §39, 40](#)

513B.7 Maintenance of records.

1. A small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

2. A small employer carrier shall file each March 1 with the commissioner an actuarial certification that the small employer carrier is in compliance with [this section](#) and that the rating methods of the small employer carrier are actuarially sound. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

3. A small employer carrier shall make the information and documentation described in [subsection 1](#) available to the commissioner upon request. The information is not a public record or otherwise subject to disclosure under [chapter 22](#), and is considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the division except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

[91 Acts, ch 244, §7; 97 Acts, ch 103, §22; 98 Acts, ch 1100, §68; 2017 Acts, ch 148, §41](#)

513B.8 Reserved.

513B.9 Reserved.

513B.9A Eligibility to enroll.

1. A carrier offering group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- a. Health status.
- b. Medical condition, including both physical and mental conditions.
- c. Claims experience.
- d. Receipt of health care.
- e. Medical history.
- f. Genetic information.
- g. Evidence of insurability, including conditions arising out of acts of domestic violence.
- h. Disability.

2. [Subsection 1](#) does not require group health insurance coverage to provide particular benefits other than those provided under the terms of the coverage, and does not prevent a coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the coverage.

3. Rules for eligibility to enroll under group health insurance coverage include rules defining any applicable waiting periods for such enrollment.

4. a. A carrier offering health insurance coverage shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage.

b. Paragraph “a” shall not be construed to do either of the following:

- (1) Restrict the amount that an employer may be charged for health insurance coverage.
- (2) Prevent a carrier offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

[97 Acts, ch 103, §23](#); [2017 Acts, ch 148, §42 - 44](#)

513B.10 Availability of coverage.

1. a. A carrier that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under [this chapter](#).

b. A carrier that offers health insurance coverage in the small group market through a network plan may do either of the following:

(1) Limit employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan.

(2) Deny such coverage to such employers within the service area of such plan if the carrier has demonstrated to the applicable state authority both of the following:

(a) The carrier will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees.

(b) The carrier is applying this subparagraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents, or any health status-related factor relating to such employees or dependents.

c. A carrier, upon denying health insurance coverage in any service area pursuant to paragraph “b”, subparagraph (2), shall not offer coverage in the small group market within such service area for a period of one hundred eighty days after the date such coverage is denied.

d. A carrier may deny health insurance coverage in the small group market if the issuer has demonstrated to the commissioner both of the following:

(1) The carrier does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier is applying the provisions of this paragraph uniformly to all employers in the small group market in this state consistent with state law and without regard to the claims experience of those employers and the employees and dependents of such employers, or any health status-related factor relating to such employees and their dependents.

e. A carrier, upon denying health insurance coverage pursuant to paragraph “d”, shall not offer coverage in connection with health insurance coverages in the small group market in this state for a period of one hundred eighty days after the date such coverage is denied or until the carrier has demonstrated to the commissioner that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later. The commissioner may provide for the application of this paragraph on a service area-specific basis.

f. Paragraph “a” shall not be construed to preclude a carrier from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in the small group market.

2. A carrier, subject to [subsection 1](#), shall issue health insurance coverage to an eligible small employer that applies for the coverage and agrees to make the required premium payments and satisfy the other reasonable provisions of the health insurance coverage not inconsistent with [this chapter](#). A carrier is not required to issue health insurance coverage to a self-employed individual who is covered by, or is eligible for coverage under, health insurance coverage offered by an employer.

3. Health insurance coverage for small employers shall satisfy all of the following:

a. A carrier offering group health insurance coverage, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. However, genetic information shall not be treated as a condition under this subparagraph in the absence of a diagnosis of the condition related to such information.

(2) The exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date.

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

b. A carrier offering group health insurance coverage shall not impose any preexisting condition exclusion as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. A carrier shall waive any waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of [this section](#), “*affiliation period*” means a period of time not to exceed sixty days for new entrants and not to exceed ninety days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors. This paragraph does not preclude application of a waiting period applicable to all new

enrollees under the health insurance coverage, provided that any carrier-imposed waiting period is no longer than sixty days and is used in lieu of a preexisting condition exclusion.

d. Health insurance coverage may exclude coverage for late enrollees for preexisting conditions for a period not to exceed eighteen months.

e. (1) Requirements used by a carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(2) In applying minimum participation requirements with respect to a small employer, a carrier shall not consider employees or dependents who have other creditable coverage in determining whether the applicable percentage of participation is met.

(3) A carrier shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

f. (1) If a carrier offers coverage to a small employer, the carrier shall offer coverage to all eligible employees of the small employer and the employees' dependents. A carrier shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

(2) Except as provided under paragraphs "a" and "d", a carrier shall not modify health insurance coverage with respect to a small employer or any eligible employee or dependent through riders, endorsements, or other means, to restrict or exclude coverage or benefits for certain diseases, medical conditions, or services otherwise covered by the health insurance coverage.

g. A carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to [subsection 1](#) with respect to a small employer where any of the following applies:

(1) The small employer does not have eligible individuals who live, work, or reside in the service area for the network plan.

(2) The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier, if required, has demonstrated to the commissioner that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees and that it is applying the requirements of this lettered paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and the employees' dependents, or any health status-related factor relating to such employees and dependents.

(3) A carrier, upon denying health insurance coverage in a service area pursuant to subparagraph (2), shall not offer coverage in the small employer market within such service area for a period of one hundred eighty days after the coverage is denied.

4. A carrier shall not be required to offer coverage to small employers pursuant to [subsection 1](#) for any period of time where the commissioner determines that the acceptance of the offers by small employers in accordance with [subsection 1](#) would place the carrier in a financially impaired condition.

5. A carrier shall not be required to provide coverage to small employers pursuant to [subsection 1](#) if the carrier elects not to offer new coverage to small employers in this state. However, a carrier that elects not to offer new coverage to small employers under [this subsection](#) shall be allowed to maintain its existing policies in the state, subject to the requirements of [section 513B.5](#).

6. A carrier that elects not to offer new coverage to small employers pursuant to [subsection 5](#) shall provide notice to the commissioner and is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner.

[92 Acts, ch 1167, §11; 93 Acts, ch 80, §7 – 9, 20; 97 Acts, ch 103, §24; 98 Acts, ch 1100, §69; 2001 Acts, ch 69, §16, 17, 39; 2017 Acts, ch 148, §45](#)

Referred to in [§513B.12](#)

513B.11 Notice of intent to operate as a risk-assuming carrier or reinsuring carrier.

1. *a.* Upon the approval of a plan of operation by the commissioner under [section 513B.13, subsection 4](#), a small employer carrier authorized to transact the business of insurance in this state shall notify the commissioner of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. The notification shall be made as deemed appropriate by the commissioner. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to [section 513B.12](#).

b. The notification of the commissioner concerning the carrier's intention pursuant to paragraph "a" is binding for a five-year period from the date notification is given, except that the initial notification given by carriers after July 1, 1992, is binding for a two-year period. The commissioner may permit a carrier to modify the carrier's decision at any time for good cause.

c. The commissioner shall establish an application process for small employer carriers seeking to change their status pursuant to [this subsection](#). If a small employer carrier has been acquired by another such carrier, the commissioner may waive or modify the time periods established in paragraph "b".

2. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health insurance coverage with the program. The carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

[92 Acts, ch 1167, §12; 93 Acts, ch 80, §10; 97 Acts, ch 103, §25](#)

513B.12 Application to become a risk-assuming carrier.

1. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

2. In evaluating an application made pursuant to [this section](#), the commissioner shall consider the following factors:

a. The carrier's financial condition.

b. The carrier's history of rating and underwriting small employer groups.

c. The carrier's commitment to market fairly to all small employers in the state or the carrier's established geographic service area, as applicable.

d. The carrier's experience with managing the risk of small employer groups.

3. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety days of the receipt of the application by the commissioner, the carrier may request a hearing.

4. The commissioner may rescind the approval granted to a risk-assuming carrier under [this section](#) if the commissioner finds any of the following:

a. The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with [section 513B.10](#) without the protection provided by the program.

b. The carrier has failed to market fairly to all small employers in the state or the carrier's established geographic service area, as applicable.

c. The carrier has failed to provide coverage to eligible small employers as required under [section 513B.10](#).

5. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of [section 513B.13](#).

6. During the period of time that the operation of the small employer carrier reinsurance program is suspended pursuant to [section 513B.13, subsection 14](#), a small employer carrier is not required to make an application to become a risk-assuming carrier pursuant to [this section](#).

[92 Acts, ch 1167, §13; 2005 Acts, ch 70, §8](#)

Referred to in [§513B.11](#)

513B.13 Small employer carrier reinsurance program.

1. A nonprofit corporation is established to be known as the Iowa small employer health reinsurance program.

2. A reinsuring carrier is subject to this program.

3. *a.* The program shall operate subject to the supervision and control of a board. Subject to the provisions of paragraph “*b*”, the board shall consist of nine members appointed by the commissioner, and the commissioner or the commissioner’s designee, who shall serve as an ex officio member and as chairperson of the board.

b. In appointing the members of the board, the commissioner shall include representatives of small employers and small employer carriers and such other individuals as determined to be qualified by the commissioner. At least five of the members of the board shall be representatives of carriers and shall be selected from individuals nominated by small employer carriers in this state pursuant to procedures and guidelines provided by rule of the commissioner.

c. Members shall be appointed for terms of three years. A board member’s term shall continue until the member’s successor is appointed.

d. A vacancy in the board shall be filled by the commissioner for the remainder of the term. A member of the board may be removed by the commissioner for cause.

e. During the period of time that the program is suspended pursuant to [subsection 14](#), the size of the board may be reduced with the approval of the commissioner.

4. The board may submit a plan of operation to the commissioner. The commissioner, after notice and hearing, may approve a plan of operation if the commissioner determines that the plan is suitable to assure the fair, reasonable, and equitable administration of the program, and provides for the sharing of program gains and losses on an equitable and proportionate basis in accordance with the provisions of [this section](#). A plan of operation is effective upon written approval of the commissioner.

5. The board may submit to the commissioner any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The amendments shall be effective upon the written approval of the commissioner.

6. The plan of operation shall do all of the following:

a. Establish procedures for the handling and accounting of program assets and moneys, and for an annual fiscal reporting to the commissioner.

b. Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier.

c. Establish procedures for reinsuring risks in accordance with the provisions of [this section](#).

d. Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program.

e. Establish a methodology for applying the dollar thresholds contained in [this section](#) for carriers that pay or reimburse health care providers through capitation or a salary.

f. Provide for any additional matters necessary to implement and administer the program.

7. The same general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business in this state may be exercised by the board under the program, except the power to issue health insurance coverages directly to either groups or individuals. Additionally, the board is granted the specific authority to do all or any of the following:

a. Enter into contracts as necessary or proper to administer the provisions and purposes of [this subchapter](#), including the authority, with the approval of the commissioner, to enter into contracts with similar programs in other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.

b. Sue or be sued, including taking any legal action necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers.

c. Take any legal action necessary to avoid the payment of improper claims made against the program.

d. Define the health insurance coverages for which reinsurance will be provided, and issue reinsurance policies, pursuant to [this subchapter](#).

- e. Establish rules, conditions, and procedures for reinsuring risks under the program.
 - f. Establish and implement actuarial functions as appropriate for the operation of the program.
 - g. Assess reinsuring carriers in accordance with the provisions of [subsection 11](#), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.
 - h. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program.
 - i. Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.
8. A reinsuring carrier may reinsure with the program as provided in [this section](#).
- a. The program shall reinsure up to the level of coverage provided in either a basic health benefit plan or standard health benefit plan established by the board.
 - b. A small employer carrier may reinsure an entire employer group within sixty days of the commencement of the group's coverage under health insurance coverage.
 - c. A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty days following the commencement of the coverage with the small employer. A newly eligible employee or dependent of a reinsured small employer may be reinsured within sixty days of the commencement of such person's coverage.
 - d. (1) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the small employer carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for ten percent of the next fifty thousand dollars of incurred claims during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subparagraph shall not exceed a maximum limit of ten thousand dollars in any one calendar year with respect to any reinsured individual.
 - (2) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the small employer carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "consumer price index for all urban consumers" of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.
 - e. A small employer carrier may terminate reinsurance for one or more of the reinsured employees or dependents of a small employer on any plan anniversary date.
 - f. Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. §300e(c)(2)(A), and is thereby subject to requirements that limit the amount of risk that may be ceded to the program that are more restrictive than those specified in paragraph "d", shall be reduced to reflect that portion of the risk above the amount set forth in paragraph "d" that may not be ceded to the program, if any.
9. a. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to [this section](#). The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, which shall be multiplied by the factors set forth in paragraph "b" to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health insurance coverages with benefits similar to the standard health benefit plan.
- b. Premiums for the program shall be as follows:
 - (1) An entire small employer group may be reinsured for a rate that is one and one-half

times the base reinsurance premium rate for the group established pursuant to [this subsection](#).

(2) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to [this subsection](#).

c. The board periodically shall review the methodology established under paragraph “a”, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

10. If health insurance coverage for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in [section 513B.4](#).

11. a. Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

b. Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(1) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on both of the following:

(a) Each reinsuring carrier’s share of the total premiums earned in the preceding calendar year from health insurance coverages delivered or issued for delivery to small employers in this state by reinsuring carriers.

(b) Each reinsuring carrier’s share of the premiums earned in the preceding calendar year from newly issued health insurance coverages delivered or issued for delivery during such calendar year to small employers in this state by reinsuring carriers.

(2) The formula established pursuant to subparagraph (1) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of the reinsuring carrier’s total premiums earned in the preceding calendar year from health insurance coverages delivered or issued for delivery to small employers in this state by reinsuring carriers to total premiums earned in the preceding calendar year from health insurance coverages delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(3) The board, with approval of the commissioner, may change the assessment formula established pursuant to subparagraph (1) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to premiums from all health insurance coverages and to premiums from newly issued health insurance coverages to vary during a transition period.

(4) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. §300e et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(5) Premiums and benefits paid by a reinsuring carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

c. (1) Prior to March 1 of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(2) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph (3), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety days following the end of the calendar year in which the losses were incurred. The evaluation shall include: an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged, and the level of insurer retention

under the program and the costs of coverage for small employers. If the board fails to file the report with the commissioner within ninety days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.

(3) For any calendar year, the amount specified in this subparagraph is five percent of total premiums earned in the previous year from health insurance coverages delivered or issued for delivery to small employers in this state by reinsuring carriers.

(4) If assessments in each of two consecutive calendar years exceed by ten percent the amount specified in subparagraph (3), the commissioner may relieve carriers from any or all of the regulations of [this subchapter](#) or take such other actions as the commissioner deems equitable and necessary to spread the risk of loss and assure portability of coverages and continuity of benefits so as to reduce assessments to ten percent or less of that amount specified in subparagraph (3).

d. If assessments exceed net losses of the program, the excess shall be held in an interest-bearing account and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, “*future losses*” includes reserves for incurred but not reported claims.

e. Each reinsuring carrier’s proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

f. The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

g. A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in [this subsection](#). The reinsuring carrier receiving such deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the program until such time as it pays such assessments.

12. The participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, or any other joint or collective action required by [this subchapter](#) shall not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

13. The program is exempt from any and all state or local taxes.

14. The board of the Iowa small employer health reinsurance program, on an ongoing basis, shall review the program and make recommendations as to the continued cost effectiveness of the program to the commissioner, which recommendations may include proposed modifications or suspension of operation of the program. In making such a review, the board shall consider such factors as the population reinsured by the program, the premiums and assessments paid to the program, the number and percentage of carriers electing to utilize the program, health care reform measures implemented in the state, as well as other factors deemed relevant by the board. The commissioner, upon finding that the program is not cost effective, may make modifications to the program or suspend the operation of the program by rule.

[92 Acts, ch 1167, §14; 93 Acts, ch 80, §11, 12; 97 Acts, ch 103, §26 – 32; 99 Acts, ch 165, §8; 2001 Acts, ch 69, §18 – 22, 39; 2005 Acts, ch 70, §9; 2014 Acts, ch 1092, §182, 183](#)

Referred to in [§513B.2](#), [513B.4](#), [513B.11](#), [513B.12](#)

513B.14 Health benefit plan standards. Repealed by [2001 Acts, ch 69, §38, 39](#).

513B.15 Periodic market evaluation.

The board shall study and report at least every three years to the commissioner on the effectiveness of [this subchapter](#). The report shall analyze the effectiveness of the subchapter

in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report shall address whether carriers and producers are fairly and actively marketing or issuing health insurance coverages to small employers in fulfillment of the purposes of [this subchapter](#). The report may contain recommendations for market conduct or other regulatory standards or action.

[92 Acts, ch 1167, §16](#); [97 Acts, ch 103, §33](#)

513B.16 Applicability of certain state laws. Repealed by [2001 Acts, ch 69, §38, 39](#).

513B.17 Discretion of the commissioner.

1. The commissioner may suspend all or any part of [section 513B.4](#) as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

2. The commissioner may suspend or modify the normal workweek requirement of thirty or more hours under the definition of eligible employee upon a finding by the commissioner that the suspension would enhance the availability of health insurance to employees of small employers.

3. The commissioner may adopt, by rule or order, transition provisions to facilitate the implementation and administration of [this chapter](#).

[91 Acts, ch 244, §8](#)

CS91, §513B.8

[92 Acts, ch 1167, §18](#)

C93, §513B.17

[93 Acts, ch 80, §14](#); [97 Acts, ch 103, §34](#); [2005 Acts, ch 70, §10](#)

513B.17A Restoration of terminated coverage. Repealed by [2001 Acts, ch 69, §38, 39](#).

513B.18 Uniform application form.

The commissioner shall develop, by rule, a uniform application form for use by small employers applying for new health insurance coverage under group health plans offered by small employer carriers. Small employer carriers shall be required to use the uniform application form not less than six months after the rules developing the form become effective under [chapter 17A](#).

[2007 Acts, ch 169, §1](#)

513B.19 through 513B.30 Reserved.

SUBCHAPTER II

BASIC BENEFIT COVERAGE

513B.31 through 513B.43 Repealed by [2001 Acts, ch 69, §38, 39](#).